STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00102878. Complaint IN00102878-Substantiated. Federal/state deficiency related to the allegations are cited at F 223, F225, F 226. Unrelated deficiencies are cited. Survey dates: January 30, 31, 2012 and February 1, 2012 Facility number: 000250 Provider Number: 155359 AIM Number: 100289980 Survey team: Ann Armey, RN Census bed type: SNF/NF: 45 Total: 45 Census payor type: Medicare: 6 Medicaid: 31 Other: 8 Total: 45 Sample: 5	F0000	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared soley because it is required by State and Federal law.Date of Compliance 2/21/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC !6.2. Quality review completed on February 7, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record review, the facility failed to ensure residents were free from physical, verbal and mental abuse. This deficiency affected 2 of 3 residents with allegation of staff to resident abuse, whose records were reviewed, in a sample of 5. (Resident #C and Resident #D) Findings include: 1. On 1/30/12 at 10:00 a.m., LPN #1 indicated there had been an abuse investigation regarding Resident #C and two employees had been terminated. The clinical record of Resident #C was reviewed on 1/30/12 at 2:00 p.m., and indicated the resident was admitted to the facility on 6/28/11, with diagnoses which included but were not limited to, dementia and anxiety. The MDS (Minimum Data Set Assessment), dated 1/17/12, indicated the resident had long and short tem memory problems with difficulty making	F0223	F223 Abuse and Neglect-Self reports confirmed1. Resident is no longer in the facility unable to apply corrective actions. Investigation was completed related to alleged aqbuse and neglect facility followed ISDH guidelines for reportable incidence. Resident #C remains in the facility.2. Facility completed investigation per ISDH guidelines. Facility conducted resident interviews to determine if there were any other instances of abuse. There were no other reports. 3. Staff re-ducated on policy and procedure related to behavior manage ment and change in condition. Interdisiplinary team will conduct resident interview thru use of Guardian Angel weekly to ensure alleged abuse of behaviors are acted on appropriately.Administrator or designee will review weekly the facility grievance log for completion of identified concerns related to abuse and behaviors.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for hygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the resident was saying "This is my house I don't want you here." At 11:15 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. At 11:30 p.m., " c (with) assistance from the CNA was able to inject res (resident) as ordered-." At 1:00 a.m., the resident was resting in bed. The note indicated "took a little over an hour to get res (resident) to quit hitting staff et (and) pacing c (with) w/c (wheelchair) after injection. On 12/1/11 at 9:30 a.m., nursing notes indicated the resident was observed to have two bruises on her right forearm measuring 3 cm by 2 cm and 2 cm by 2 cm. A facility incident reporting form		months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the CNA #2 and LPN #3, who had been caring for Resident #C on the night shift, were suspended on 12/1/11, pending an investigation of allegations of verbal and physical abuse. An investigative statement, dated 12/1/11, taken from CNA #2, indicated she saw LPN #3 hit Resident #C. An investigative statement, dated 12/1/11, from the LPN #4, indicated that, during report, between the evening and night shift on 11/30/11, she could hear LPN #3 and CNA #2 yelling at Resident #C. The statement indicated "At one point I heard the resident yell 'ouch' and saw her holding her left arm when she came out of the room..." An investigative statement, dated 12/1/11, from the acting DON (No longer employed by the facility) indicated "Upon entering (Resident #C's name) room to ask if we may perform a skin check due to allegations of abuse, the resident stated to me that she did not like that nurse last night because she was mean and argued with me than (sic) she "hit me"...two bruises were noted to right forearm..." The final incident reporting form, undated, indicated both LPN #3 and CNA #2 were terminated. "...Resident monitored for any negative outcomes which currently are none. Family and MD notified on 12/1/2011 of alligation (sic) and bruises."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The Employee Coaching Plan, for LPN #3, dated 12/7/11, indicated the employee was terminated for verbal and physical abuse.

The Employee Coaching Plan, dated 12/7/11, for CNA #2, indicated the employee was terminated for failure to report physical abuse.

On 1/30/12 at 5:00 p.m., the Administrator was interviewed and indicated she was not aware of the incident until the morning of 12/1/11. The Administrator indicated LPN #4, who was one of the night nurses, reported the altercation between LPN #2 and Resident #C to the day shift Nurses, on 12/1/11. The Administrator indicated, LPN #3 and CNA #2 were suspended, an investigation was initiated and statements were taken from the individuals involved. She indicated CNA #2 did not report that she saw LPN #3 hit the resident until they questioned her. The Administrator indicated two additional nurses (LPN #4 and LPN #5) received disciplinary warnings because they did not immediately intervene when they heard the altercation taking place and because they did not report the altercation immediately to the administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The clinical record of Resident #D was reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder. On 11/14/11 at 4:50 p.m., nursing notes indicated Resident #D was yelling, screaming, throwing wreath off door and tossing a wheel chair across the hall. A statement in an investigative report, unsigned, dated 11/15/11, indicated CNA #6 was suspended because he made faces at Resident #D causing her "...to become agitated throwing items in her room and refusing medication..." The statement also indicated CNA #6 came up behind Resident #D and poked her causing her to be startled and agitated. An investigative statement, dated 11/16/11, written by RN #16 indicated "I began work @ (at) 2:30 p on Monday 11-14-2011....(CNA #6's name) bent down and hugged (Resident #D). Resident (Resident #D's name) became very upset & (and) irritated. Resident then began yelling & screaming saying 'keep your hands off me (CNA #6's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	name)...Resident then heads down the hall to her room...'." The statement further indicated Resident #D thought RN #16 was lying about her medicine and indicated CNA #6 was making faces at her. The final incident reporting form, undated, indicated "After full investigation, the alligation (sic) was substantiated and employee immediately terminated,..." The Coaching Plan, dated 11/17/11, indicated CNA #6 was terminated because the employee caused mental distress to a resident. On 1/31/12 at 10:05 a.m., the Administrator indicated Resident #D reported the allegation of mental abuse to her on 11/15/11 at 11:00 a.m. The Administrator indicated the resident told her on 11/14/11, during the evening shift, CNA #6 made faces at her. The Administrator indicated the CNA was immediately suspended and an investigation was conducted. The Administrator indicated the investigation confirmed CNA #6's behavior had caused the resident mental distress. This Federal tag relates to Complaint			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	IN00102878. 3.1-27(a)(1) 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interviews and record review, the facility failed to ensure staff reported allegations of abuse immediately to the administrator for 2 of 3 residents with	F0225	F225 Reporting allegations of abuse1. Resident is no longer in the facility unable to apply corrective actions. Investigation was completed related to alleged	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	allegations of staff to resident abuse in a sample of 5. (Resident #C and Resident #D) The findings include: 1. On 1/30/12 at 10:00 a.m., LPN #1 indicated there had been an abuse investigation regarding Resident #C and two employees had been terminated. The clinical record of Resident #C was reviewed on 1/30/12 at 2:00 p.m., and indicated the resident was admitted to the facility on 6/28/11, with diagnoses which included but were not limited to, dementia and anxiety. The MDS (Minimum Data Set Assessment), dated 1/17/12, indicated the resident had long and short tem memory problems with difficulty making decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for hygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the		aqbuse and neglect facility followed ISDH guidelines for reportable incidence. Resident #C remains in the facility.2. Facility completed investigation per ISDH guidelines. Facility conducted resident interviews to determine if there were any other instances of abuse. There were no other reports. 3. Staff re-ducated on policy and procedure related to behavior manage ment and change in condition. Interdisiplinary team will conduct resident interview thru use of Guardian Angel weekly to ensure alleged abuse of behaviors are acted on appropriately.Administrator or designee will review weekly the facility grievance log for completion of identified concerns related to abuse and behaviors.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was saying "This is my house I don't want you here." At 11:15 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. At 11:30 p.m., " c (with) assistance from the CNA was able to inject res (resident) as ordered-." At 1:00 a.m., the resident was resting in bed. The note indicated "took a little over an hour to get res (resident) to quit hitting staff et (and) pacing c (with) w/c (wheelchair) after injection. On 12/1/11 at 9:30 a.m., nursing notes indicated the resident was observed to have two bruises on her right forearm measuring 3 cm by 2 cm and 2 cm by 2 cm. A facility incident reporting form indicated the CNA #2 and LPN #3, who had been caring for Resident #C on the night shift, were suspended on 12/1/11, pending an investigation of allegations of verbal and physical abuse. An investigative statement, dated 12/1/11, taken from CNA #2, indicated she saw LPN #3 hit resident #C. An investigative statement, dated 12/1/11, from the LPN #4, indicated that during report, between the evening and night shift on 11/30/11, she could hear LPN #3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and CNA #2 yelling at Resident #C. The statement indicated "At one point I heard the resident yell 'ouch' and saw her holding her left arm when she came out of the room..." An investigative statement, dated 12/1/11, from the acting DON (No longer employed by the facility) indicated "Upon entering (Resident #C's name) room to ask if we may perform a skin check due to allegations of abuse, the resident stated to me that she did not like that nurse last night because she was mean and argued with me than (sic) she "hit me"...two bruises were noted to right forearm..." The final incident reporting form, undated, indicated both LPN #3 and CNA #2 were terminated. "...Resident monitored for any negative outcomes which currently are none. Family and MD notified on 12/1/2011 of alligation (sic) and bruises." The Employee Coaching Plan, for LPN #3, dated 12/7/11, indicated the employee was terminated for verbal and physical abuse. The Employee Coaching Plan, dated 12/7/11, for CNA #2, indicated the employee was terminated for failure to report physical abuse. On 1/30/12 at 5:00 p.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator was interviewed and indicated she was not aware of the incident until the morning of 12/1/11. The Administrator indicated LPN #4, who was one of the night nurses, reported the altercation between LPN #2 and Resident #C to the day shift Nurses, on 12/1/11. The Administrator indicated, LPN #3 and CNA #2 were suspended, an investigation was initiated and statements were taken from the individuals involved. She indicated CNA #2 did not report that she saw LPN #3 hit the resident until they questioned her. The Administrator indicated two additional nurses (LPN #4 and LPN #5) received disciplinary warnings because they did not immediately intervene when they heard the altercation taking place and because they did not report the altercation immediately to the administrator. 2. The clinical record of Resident #D was reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder. On 11/14/11 at 4:50 p.m., nursing notes indicated Resident #D was yelling,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	screaming, throwing wreath off door and tossing a wheel chair across the hall. A statement in an investigative report, unsigned, dated 11/15/11, indicated CNA #6 was suspended because he made faces at Resident #D causing her "...to become agitated throwing items in her room and refusing medication..." The statement also indicated CNA #6 came up behind Resident #D and poked her causing her to be startled and agitated. An investigative statement, dated 11/16/11, written by RN #16 indicated "I began work @ (at) 2:30 p on Monday 11-14-2011....(CNA #6's name) bent down and hugged (Resident #D). Resident (Resident #D's name) became very upset & (and) irritated. Resident then began yelling & screaming saying 'keep your hands off me (CNA #6's name)...Resident then heads down the hall to her room...' The statement further indicated Resident #D thought RN #16 was lying about her medicine and indicated CNA #6 was making faces at her. The final incident reporting form, undated, indicated "After full investigation, the alligation (sic) was substantiated and employee immediately terminated,..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Coaching Plan, dated 11/17/11, indicated CNA #6 was terminated because the employee caused mental distress to a resident. On 1/31/12 at 10:05 a.m., the Administrator indicated Resident #D reported the allegation of mental abuse to her on 11/15/11 at 11:00 a.m. The Administrator indicated the resident told her on 11/14/11, during the evening shift, CNA #6 made faces at her. The Administrator indicated the CNA was immediately suspended and an investigation was conducted. The Administrator indicated the investigation confirmed CNA #6's behavior had caused the resident mental distress. This Federal tag relates to Complaint IN00102878. 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	A. Based on interviews and record review, the facility failed to ensure facility staff followed established policies regarding reporting allegations of abuse immediately to the administrator for 2 of 3 residents with allegations of staff to resident abuse in a sample of 5. (Resident #C and Resident #D) B. Based on interviews and record reviews, the facility failed to follow policies to complete reference checks on an employee terminated for abuse and failed to have reference checks in the personnel files of five of five employees, who were recently hired. This deficiency affected 6 of eight employee files reviewed. (CNAs #6, #7, #8, #9, #10, #11) The findings include: A.1. On 1/30/12 at 10:00 a.m., LPN #1 indicated there had been an abuse investigation regarding Resident #C and two employees had been terminated. The clinical record of Resident #C was reviewed on 1/30/12 at 2:00 p.m., and indicated the resident was admitted to the	F0226	F226 Reporting allegations of abuse1. Resident is no longer in the facility unable to apply corrective actions. Investigation was completed related to alleged aqbuse and neglect facility followed ISDH guidelines for reportable incidence. Resident #C remains in the facility.All current employee files were audited for reference checks. The administrator or designee will audit all new employee files for completion of reference checks. This information will be submitted to QA for review.2. Facility completed investigation per ISDH guidelines. Facility conducted resident interviews to determine if there were any other instances of abuse. There were no other reports. 3. Staff re-ducated on policy and procedure related to behavior manage ment and change in condition. Interdisiplinary team will conduct resident interview thru use of Guardian Angel weekly to ensure alleged abuse of behaviors are acted on appropriately.Administrator or designee will review weekly the facility grievance log for completion of identified concerns related to abuse and behaviors.4. Results of these QA reviews will be forwared to the	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility on 6/28/11, with diagnoses which included but were not limited to, dementia and anxiety. The MDS (Minimum Data Set Assessment), dated 1/17/12, indicated the resident had long and short tem memory problems with difficulty making decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for hygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the resident was saying "This is my house I don't want you here." At 11:15 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. At 11:30 p.m., " c (with) assistance from the CNA was able to inject res (resident) as ordered-." At 1:00 a.m., the resident was resting in bed. The note indicated "took a little over an hour to get res (resident) to quit hitting staff et (and) pacing c (with) w/c (wheelchair) after injection.		facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/1/11 at 9:30 a.m., nursing notes indicated the resident was observed to have two bruises on her right forearm measuring 3 cm by 2 cm and 2 cm by 2 cm. A facility incident reporting form indicated the CNA #2 and LPN #3, who had been caring for Resident #C on the night shift, were suspended on 12/1/11, pending an investigation of allegations of verbal and physical abuse. An investigative statement, dated 12/1/11, taken from CNA #2, indicated she saw LPN #3 hit resident #C. An investigative statement, dated 12/1/11, from the LPN #4, indicated that, during report, between the evening and night shift on 11/30/11, she could hear LPN #3 and CNA #2 yelling at Resident #C. The statement indicated "At one point I heard the resident yell "ouch" and saw her holding her left arm when she came out of the room..." An investigative statement, dated 12/1/11, from the acting DON (No longer employed by the facility) indicated "Upon entering (Resident #C's name) room to ask if we may perform a skin check due to allegations of abuse, the resident stated to me that she did not like that nurse last night because she was mean and argued with me than (sic) she "hit me"...two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bruises were noted to right forearm..." The final incident reporting form, undated, indicated both LPN #3 and CNA #2 were terminated. "...Resident monitored for any negative outcomes which currently are none. Family and MD notified on 12/1/2011 of alligation (sic) and bruises." The Employee Coaching Plan, for LPN #3, dated 12/7/11, indicated the employee was terminated for verbal and physical abuse. The Employee Coaching Plan, dated 12/7/11, for CNA #2, indicated the employee was terminated for failure to report physical abuse. On 1/30/12 at 5:00 p.m., the Administrator was interviewed and indicated she was not aware of the incident until the morning of 12/1/11. The Administrator indicated LPN #4, who was one of the night nurses, reported the alteraction between LPN #2 and Resident #C to the day shift Nurses, on 12/1/11. The Administrator indicated, LPN #3 and CNA #2 were suspended, an investigation was initiated and statements were taken from the individuals involved. She indicated CNA #2 did not report that she saw LPN #3 hit the resident until they questioned her. The Administrator			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated two additional nurses (LPN #4 and LPN #5) received disciplinary warnings because they did not immediately intervene when they heard the altercation taking place and because they did not report the altercation immediately to the administrator. A.2. The clinical record of Resident #D was reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder. On 11/14/11 at 4:50 p.m., nuring notes indicated Resident #D was yelling, screaming, throwing wreath off door and tossing a wheel chair across the hall. A statement in an investigative report, unsigned, dated 11/15/11, indicated CNA #6 was suspended because he made faces at Resident #D causing her "...to become agitated throwing items in her room and refusing medication..." The statement also indicated CNA #6 came up behind Resident #D and poked her causing her to be startled and agitated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An investigative statement, dated 11/16/11, written by RN #16 indicated "I began work @ (at) 2:30 p on Monday 11-14-2011....(CNA #6's name) bent down and hugged (Resident #D). Resident (Resident #D's name) became very upset & (and) irritated. Resident then began yelling & screaming saying "keep your hands off me (CNA #6's name)...Resident then heads down the hall to her room..." The statement further indicated Resident #D thought RN #16 was lying about her medicine and indicated CNA #6 was making faces at her. The final incident reporting form, undated, indicated "After full investigation, the alligation (sic) was substantiated and employee immediately terminated,..." The Coaching Plan, dated 11/17/11, indicated CNA #6 was terminated because the employee caused mental distress to a resident. On 1/31/12 at 10:05 a.m., the Administrator indicated Resident #D reported the allegation of mental abuse to her on 11/15/11 at 11:00 a.m. The Administrator indicated the resident told her on 11/14/11, during the evening shift, CNA #6 made faces at her.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Administrator indicated the CNA was immediately suspended and an investigation was conducted. The Administrator indicated the investigation confirmed CNA #6's behavior had caused the resident mental distress. B. On 1/31/12 at 10:00 a.m., employee records were reviewed. The employee record of CNA #6, who was terminated on 11/17/11 for mental abuse, was reviewed. The CNA was hired on 8/10/11. There was no documentation the references of CNA #6 were checked. Five most recently hired employees were reviewed, including: CNAs #7 with a hire date of 12/23/11, CNA #8 with a hire dated of 12/28/11, CNA #9 with a hire dated of 1/4/12, CNA #10 with a hire dated of 1/4/12, and CNA #11 with a hire date of 1/4/12. None of the CNAs had documentation their references had been checked prior to employment. On 1/31/12 at 1:30 p.m., the Administrator was interviewed and indicated there was no evidence that CNA #6's references had been checked. The Administrator indicated the five most			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recently hired employees references had been checked by the Unit Manager but the information had not been documented on the reference check forms used by the facility. The Administrator said the reference information was documented on notes that were in the Unit Manager's office. The Administrator indicated the Unit Manager should have documented the information on the facility's reference check forms and placed in the employees files. On 2/1/12 at 4:30 p.m., the Unit Manager brought in note with reference information for CNA #9, which included the person contacted and response, but did not include the date and time the person was contacted. The Abuse Prevention Program & (and) Policy, revised 11/11, provided by the Administrator was reviewed on 1/31/12, at 1:45 p.m. and indicated, "...Screen all potential employees for a history of abuse, neglect, or mistreating residents/patients during the hiring process. Screening will consist of, but not be limited to:...Reference checks from previous and/or current employers... "The facility prohibits the mistreatment, neglect, and abuse of residents/patients... Report an incident immediately to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator, and Director of Nursing... Provide for the immediate safety of the resident/patient upon identification of suspected abuse.... This Federal tag relates to Complaint IN00102878. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to develop careplans with behavioral interventions for 2 of 3 residents, who were reviewed with histories of suicidal ideation, in a sample of 5. (Resident #D and Resident #F) Findings include: 1. The closed clinical record of Resident #D was reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, after she cut her left wrist and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder with suicidal thoughts and attempt. Resident #D was discharged from the facility on 11/18/11. The resident received a Behavioral medicine evaluation on 10/27/11. The note indicated the resident was receiving Cymbalta 60 mg twice daily and "Follow-up with Generations psychiatrist d/ced (discontinued) per family request." Resident was receiving cognitive behavioral therapy with the last progress	F0250	F250 Care Plans for behaviors and suicidal ideation1. Resident's identified with suicidal ideation will have assessments completed, care plans reviewed and revised to include appropriate interventions. The DON and facility will complete the initial state State reportable (24 hour report) and the five day investigation per policy.2. The DON or designee will complete a review of the nurse notes and Social Service notes of resident identified with active diagnosis of suicidal ideation or active symptoms of attempted harm to ensure that an appropriate intervention to prevent harm is in place and on care plan. The DON or designee will expand the chart review of nurses' notes and Social service over the next seven days to ensure 100% compliance.5 chart review have been completed to determine if any other issues are identified related to abuse or self harm injuries. Two resident identified. One resident was placed on every 15 minute checks, until Psychologist completes assessment and evaluation 2/2/12. Activity assessments and care plan developed2/1/12. This resident was determined that he was not at risk currently to harm himself and removed from every	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	note in the clinical record, dated 11/9/11. The note indicated the therapy was "to increase appropriate coping skills with depressive episodes." On 11/13/11 at 8:30 a.m., nursing notes indicated Resident #D was speaking of wanting to go with her deceased boyfriend and was trying to scratch herself. The note indicated the resident was placed on one on one supervision and the nurse practitioner was notified. On 11/13/11 at 11:25 p.m., was started on 15 minute checks. On 11/13/11 at 4:50 p.m., Resident #D called 911 and when the officers came to the facility, "she begged them to take her to jail because she was evil and needed to go to jail..." The note indicated the physician was notified and a new order was obtained for Ativan 0.5 mg three times daily for five days. On 11/14/11 at 4:30 p.m., social service notes indicated Resident #D was discussing the desire "to cleanse her soul." The note indicated Resident #D entered the social service office and grabbed scissors and placed them to her neck. "...writer intervened...wr (writer) offered validation for (Resident #D) regarding her feelings of wanting to join (deceased		15 minute checks. His risk per Psychologist is transferring into community and living alone. Specific behaviors to monitor for residents include: social isolation, verbalization of suicidal thoughts, feelings of being overwhelmed/anxiety-talking fast, sweating, assure swallows medication. Specific interventions to redirect and assist in calming this resident include: encourage participation in activities of his choice, educate family regarding OTC medications, staff should continue to validate the reality of his pain, but also acknowledge that most pharmacologic options have been exhausted for pain management. Physician to consider Buspar because it is non-addictiive, reorient him away from thinking a pill is going to take away all discomfort, direct him that it is his responsibility to cope with residual physical and psychological discomforts, try to focus him on physical comfort measures - warm towels, relaxation therapy, massage therapy.3. Facility administrator will re-educate Social Service Director on policy and procedure related to suicidal ideation and investigation related to abuse policy. DON or designee will re-educate staff on facility policy related to reportable serious incidents abuse policy, Behavior escalation and Crisis Management, One-On-One	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	boyfriend's name)..." The note indicated the hall nurse was notified of the event. On 11/14/11 at 5:00 p.m., the psychiatrist was notified and an order was obtained to administer Geodon 10 mg intramuscularly and Ativan 1 mg intramuscularly as soon as possible and to repeat in 12 hours. On 11/15/11-11/17/11, nursing notes indicated the resident was calm and continued on 15 minute checks. The quarterly social services assessment, dated 11/16/11, indicated the care plan was updated for wanderguard, smoking, aggression and code status. There was no indication the care plan was updated with interventions to address the resident's suicidal ideation. On 1/31/12, at 1:00 p.m., the care plan for Resident #D was reviewed with the Social Services Director and no care plan for suicidal ideation had been developed. On 11/18/11 at 8:30 a.m., nursing notes indicated "called to resident's room per staff report of noise, writer entered resident room with unit CNA, found resident c (with) pleasant mood reports dropped dish on floor. (Zero) behavior (sic) noted. Cont. (continue) with 15 min (minute) checks." On 11/18/11 at 4:00 p.m., nursing notes		Observation, and change in condition.IDT will review 24 hour report and nurse notes of residents identified with active diagnosis of suicidal ideation during the clinical meeting to ensure appropriate interventions are in place and care plans reflects appropriate interventions and appropriate allegations of abuse are reported timely and investigated appropriatley. This will be monitored as an on-going process.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

indicated "Writer notified (Psychiatrist's Name) of incident N.O. received to send to (Hospital's Name) ER (emergency room) for eval & tx (evaluation and treatment). Writer notified family. Charge nurse c (with) patient. 2nd charge nurse to assess pt. (patient)."

The Emergency Transport report, dated 11/18/11, indicated Emergency Medical Services were notified at 4:26 p.m., arrived at the facility at 4:34 p.m., and left the facility with the resident at 4:46 p.m. The dispatch complaint indicated "Hemorrhage/Laceration."

On 11/18/11 at 6:00 p.m., nursing notes indicated a second nurse called her and said Resident #D attempted to cut her neck. The note indicated "Resident was at nurses station. There was a superficial cut from ear to ear. The CNA that was watching her at the nurses station told me that (Resident #D) had broken a bowl et (and) the CNA said she thought she had cleaned (up symbol) all the pieces, but (Resident #D) must have had a piece hidden. The aid [sic] stated that she was walking et (and) saw (Resident #D) c (with) something in her hand going back and forth on her neck. The aid [sic] said she had just checked her..."

On 2/1/12 at 3:00 p.m., LPN #13, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurse on duty on 11/18/11 when Resident #D cut her neck, was interviewed. She indicated she placed a clean dressing on the resident's neck and remained with the resident until the EMS arrived. The nurse indicated the wound appeared superficial but when the resident tipped her head backward the edges of the wound gapped open. The nurse indicated the wound was not bleeding. Resident #D had a history of a suicidal attempt on 10/1/11, voiced suicidal thoughts on 11/13/11 and held a scissors to her neck and expressed suicidal thought on 11/14/11. There was no documentation the facility arranged for the resident to be assessed by the psychologist/psychiatrist, after the 11/14/11 incident. There was no documentation a care plan was developed or implement to address the resident's suicidal ideation. The Clinical Change in Condition Policy, dated 8/10 and Behavioral Management Policy, dated 9/11, provided by the DON on 2/1/12, were reviewed at 2:45 p.m., and indicated, "The interdisciplinary team strives to identify and manage all residents/patient's that are experiencing a change in condition...Daily observation includes but is not limited to changes in:...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Behavior... Assess the resident/patient clinical status when a change of condition is identified.... Review careplan goals and intervention, modify as indicated..." 2. On 2/1/12 at 10:00 a.m., the clinical record of Resident #F was reviewed and indicated the resident was admitted to the facility from a behavioral unit on 1/25/12 with diagnosis which included but were not limited to depressive disorder, chronic anxiety and chronic pain. A psychiatric assessment from the hospital, dated 1/12/12, indicated the resident had "depression with suicidal thoughts." The resident's care plan indicated the resident had multiple mental health issues including: depression with suicidal ideation; anxiety disorder, history of copied and benzodiazepine dependence; and personality disorder. The interventions included: Observe behaviors. Encourage resident to voice concerns. Encourage resident to participate in activities. Administer medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Discuss with resident statements made. Follow up with mental health consultation. If resident is restless, impatient, combative or refuses resume conversation task later. Observe for new or worsening signs and symptoms and notify physician. Monitor for signs and symptoms of suicidal ideation. The care plan did not have specific/individualized interventions regarding what behaviors were to be monitored, how the resident was going to be encouraged to voice concerns, what activities were going to be encouraged to improve his psychosocial well being , what specific arrangements for follow-up mental health assessments were to be provided, and how the resident was going to be supervised to assure his safety. The January 2012 behavior monitoring sheet indicated the resident was being monitored for verbal aggression and refusal of care. There was no documentation suicidal ideation was being monitored. On 2/1/12 at 11:00 a.m., Resident #F was interviewed. He was observed sitting in his room in his wheelchair with a tense expression on his face.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	He indicated he was very anxious and needed more pain medication because he had pain in his back going down his leg. He felt like he was going to "explode." He liked bingo but was too upset to participate in any of the activities. The DON (Director of Nursing) was notified about the resident's concerns. On 2/1/12 at 4:15 p.m., Resident #F was interviewed. He was smiling and talking with staff. He indicated he had a shower and felt so much better. He talked to the nurse practitioner and she was arranging for him to have a pain consultation. 3.1-34(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders for the administration of Procrit (a medication used to stimulate the production of red blood cells). This deficiency affected 1 of 1 residents receiving Procrit in a sample of 5. (Resident #B) Findings include The clinical record of Resident #B was reviewed on 1/30/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 9/25/07 with diagnoses which included but were not limited to, chronic kidney disease and anemia. The January 2012, MAR (Medication Administration Record) for Resident #B indicated Inject 1 ml. Procrit (20,000 units) every 2 weeks "keep HBG 10/3.3"(sic). Physician orders, dated 9/9/11, indicated the Procrit was to be held if the resident's hemoglobin was greater than 10 and or the hematocrit was greater than 33. These parameters were not on the January 2012 MAR.	F0282	F282 Significant Medication Error, facility will follow physician orders1. Resident #B had physician's order clarified and dosage and proper follow through through on MD ordor for Procrit based off monthly lab results will be followed. New order obtained for Procrit to be given if hemoglobin drops below 10. D/C'd hematocrit order.2. Facility reviewed Pharmacy list of order Procrit to ensure administratered per physicians orders.3. Licensed staff will be re-educated on facility policy related to physician orders. Facility IDT will review new orders in the daily clinical meeting to ensure medication requiring lab monitoring is completed. DON or designee will QA medications requiring lab monitoring weekly to ensure labs have been completed and medicationis administered per MD order.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician orders, dated 10/8/11, indicated the weekly CBC (Complete Blood Count) was to be discontinued and the CBC was to be done monthly. The Procrit was to be given/held twice monthly based on the Hemoglobin and Hematocrit levels but the facility was only checking the hemoglobin and hematocrit levels monthly. The CBC, dated 11/1/11, indicated the resident's Hemoglobin was 10 and the Hematocrit was 30 and as a result, the Procrit should have been given. The Procrit was signed as given 11/1/11 but was scored out with error written above the entry and there was no other documentation the Procrit was given during the month of November 2011. The CBCs done in December 2011 and January 2012 indicated the hemoglobin and hematocrits were greater than 10 and 33 respectively during both months and as a result the Procrit was not to be given. On 1/30/12 at 5:30 p.m. , the DON (Director of Nursing) indicated there was confusion with the Procrit order and the physician had clarified the order. Physician's orders, dated 1/30/12, indicated Procrit 20,000 units was to be injected subcutaneous one time monthly after CBC results to keep the hemoglobin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	greater than ten. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide increased supervision, when a resident expressed suicidal ideation and had been observed earlier to grab scissors and place them to her neck, for 1 of 3 residents reviewed with histories of suicidal ideation in a sample of 5. (Resident #D) Findings include: The closed clinical record of Resident #D was reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, after she cut her left wrist and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder with suicidal thoughts and attempt. The resident was discharged from the facility on 11/18/11. The resident received a Behavioral medicine evaluation on 10/27/11. The note indicated the resident was receiving Cymbalta 60 mg twice daily and "Follow-up with Generations psychiatrist d/ced (discontinued) per family request."	F0323	F323 Supervision of behaviors, psycholgical needs1. Resident #D is no longer at the facility. She was transferred to psychiatric hospital. Social Service was suspended pending investigation for not following Policy and Procedure and improperly communicating behavior crisis management interventions.2. Residents who exhibit mental or psychosocial issues will be interviewed by Social Service staff and referred for appropriate treatment with outside services as needs arise.3. Residents who display violent/antisocial behaviors will be reviewed immediately by reporting to the facility administrator and or DON for discussion for outside psychological assessemnts/interventions. These residents will be reviewed and monitored in the facility daily clinical meeting as issues arise and determination made by care giving team as to appropriate interventions to meet resident psychosocial needs. Staff was re-educated on notification of Administrator and DON need to be called 24/7..DON or designee will randomly QA two charts weekly for 2 months of residents with known behavioral issues to determine that facility is meeting	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident was receiving cognitive behavioral therapy with the last progress note in the clinical record, dated 11/9/11. The note indicated the therapy was "to increase appropriate coping skills with depressive episodes." On 11/13/11 at 8:30 a.m., nursing notes indicated Resident #D was speaking of wanting to go with her deceased boyfriend and was trying to scratch herself. The note indicated the resident was placed on one on one supervision and the nurse practitioner was notified. On 11/13/11 at 11:25 p.m., was started on 15 minute checks. On 11/13/11 at 4:50 p.m., Resident #D called 911 and when the officers came to the facility, "she begged them to take her to jail because she was evil and needed to go to jail..." The note indicated the physician was notified and a new order was obtained for Ativan 0.5 mg three times daily for five days. On 11/14/11 at 4:30 p.m., social service notes indicated Resident #D was discussing the desire "to cleanse her soul". The note indicated Resident #D entered the social service office and grabbed scissors and placed them to her neck. "...writer intervened...wr (writer) offered		psycho social needs of said residents until 100% compliance.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	validation for (Resident #D) regarding her feelings of wanting to join (deceased boyfriend's name)..." The note indicated the hall nurse was notified of the event. On 11/14/11 at 5:00 p.m., the psychiatrist was notified and an order was obtained to administer Geodon 10 mg intramuscularly and Ativan 1 mg intramuscularly as soon as possible and to repeat in 12 hours. On 11/15/11-11/17/11, nursing notes indicated the resident was calm and continued on 15 minute checks. The quarterly social services assessment, dated 11/16/11, indicated the care plan was updated for wanderguard, smoking, aggression and code status. There was no indication the care plan was updated with interventions to address the resident's suicidal ideation or need for increased supervision. On 1/31/12, at 1:00 p.m., the care plan for Resident #D was reviewed with the Social Services Director and no care plan for suicidal ideation had been developed. On 11/18/11 at 8:30 a.m., nursing notes indicated "called to resident's room per staff report of noise, writer entered resident room with unit CNA, found resident c (with) pleasant mood reports dropped dish on floor. (Zero) behavior			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(sic) noted. Cont. (continue) with 15 min (minute) checks." On 11/18/11 at 4:00 p.m., nursing notes indicated "Writer notified (Psychiatrist's Name) of incident N.O. received to send to (Hospital's Name) ER (emergency room) for eval & tx (evaluation and treatment). Writer notified family. Charge nurse c (with) patient. 2nd charge nurse to assess pt. (patient)." The Emergency Transport report, dated 11/18/11, indicated Emergency Medical Services were notified at 4:26 p.m., arrived at the facility at 4:34 p.m., and left the facility with the resident at 4:46 p.m. The dispatch complaint indicated "Hemorrhage/Laceration." On 11/18/11 at 6:00 p.m., nursing notes indicated a second nurse called her and said Resident #D attempted to cut her neck. The note indicated "Resident was at nurses station. There was a superficial cut from ear to ear. The CNA that was watching her at the nurses station told me that (Resident #D) had broken a bowl et (and) the CNA said she thought she had cleaned (up symbol) all the pieces, but (Resident #D) must have had a piece hidden. The aid [sic] stated that she was walking et (and) saw (Resident #D) c (with) something in her hand going back and forth on her neck. The aid [sic] said			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she had just checked her..." On 2/1/12 at 3:00 p.m., LPN #13, the nurse on duty on 11/18/11 when Resident #D cut her neck, was interviewed. She indicated she placed a clean dressing on the resident's neck and remained with the resident until the EMS arrived. The nurse indicated the wound appeared superficial but when the resident tipped her head backward the edges of the wound gapped open. The nurse indicated the wound was not bleeding. Resident #D had a history of a suicidal attempt on 10/1/11, voiced suicidal thoughts on 11/13/11 and held a scissors to her neck and expressed suicidal thought on 11/14/11. Other than the ongoing 15 minute checks, there was no documentation the resident was provided increased supervision after the 11/14/11 incident. The Clinical Change in Condition Policy, dated 8/10 and Behavioral Management Policy, dated 9/11, provided by the DON on 2/1/12, were reviewed at 2:45 p.m., and indicated, "The interdisciplinary team strives to identify and manage all residents/patient's that are experiencing a change in condition...Daily observation includes but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	is not limited to changes in:...Behavior..." "One-on-One Observation may be implemented when a resident/patient exhibits the following behavior that may include but is not limited to:... Suicidal verbalizations..." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to assure staff were washing their hands after the removal of their gloves. This deficiency	F0441	F441 Preventing the spread of infection-washing hands after removing gloves1. Residents who identified will be reassessed for signs and symptoms of	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	affected two of two staff persons observed for handwashing during care of Resident G. (RN #14 and CNA #15) Findings include: On 1/31/12 between 5:45 a.m. and 6:15 a.m., during observation care for Resident #G, the following was observed: CNA #15 washed Resident #G's peri-area. CNA #15 turned the resident to the left side and washed the resident's buttocks and then turned the resident to the right side. Resident #G was soiled with stool and additional linens were needed. CNA #15 removed her gloves and exited the room without first washing or sanitizing her hands to retrieve linen from the linen cart. CNA #15 returned to the room, donned gloves and finished washing the resident, cleaned the bed surface and positioned the resident. The CNA bagged up the soiled linen, removed her gloves, and left the room without first washing her hands. RN #14 was assisting with Resident #G's care. RN#14 donned gloves assisted in turning the resident, and placed the catheter drainage bag on the bed. RN #15 removed her gloves and left the room to retrieve linens without first washing her		infection related to allegation ofgloves worn and hand washing not completed appropriately. Staff that were observed by surveyor not following hand washing policy and or gloves worn multiple resident care will have coaching plans completed and re-education and skills observation check off completed.2. A review of residents for signs and symptoms of infection will be reviewed times 72 hours for any indication of infection control issues will be addressed immediately.3. Facility staff re-educated on policy and procedure related to hand washing completed with a visual skills check off. DON or designee will conduct daily random visual observation of staff related to care to ensure that hand washing is completed appropriately. Immediate re-education will be completed for identified concerns.4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hands. RN #14 reentered the room, donned gloves, removed a soiled dressing on Resident G's buttocks and reapplied a clean dressing that she had brought in when she entered the room, emptied the wash basin, removed her gloves and left the room without first sanitizing or washing her hands. RN #14 returned to the room with an ointment, donned gloves, and applied the ointment to the resident's arms and legs. RN #14 removed her gloves and left the room without first washing her hands. On 1/31/12 at 2:30 p.m., the DON (Director of Nursing) was interviewed and indicated staff were to wash their hands after providing care. The handwashing policy, dated 2/09, provided by the Administrator, was reviewed on 1/31/12 at 9:00 a.m., and indicated, "...Handwashing is mandated between resident/patient contact in an effort to prevent the spread of infection. Hands must be washed after the following,... removal of gloves. 3.1-18(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibility of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including but not limited to This state rule was not met as evidenced by: Based on interview and record review, the facility failed to notify the Indiana State Department of Heath of a self-inflicted injury which resulted in hospitalization. This deficiency affected 1 of 3 residents reviewed with suicidal ideation, in a sample of 5. Findings including: The clinical record of Resident #D was	F9999	F9999 Administration reporting all self reportables to ISDH1. The facility reviewed all self repotable incidents to validate all reportables were reported per ISDH policy and procedure.2. Administrator or DON will QA all self reportables to make sure they are reported timely per policy.3. Administrator was re-educated by Regional Clinical Nurse on self reportable incidents Policy and Procedure per ISDH. 4. Results of these QA reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	02/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 1/31/12 at 9:00 a.m., and indicated the resident was admitted to the facility on 6/18/10, was transferred to a psychiatric hospital on 10/1/11, after she cut her left wrist and was readmitted to the facility on 10/10/11, with diagnosis which included Schizoaffective Disorder with suicidal thoughts and attempt. On 11/18/11 at 4:00 p.m., nursing notes indicated the psychiatrist was notified of an incident and ordered the resident be sent to the emergency room for evaluation and treatment. The Emergency Transport report, dated 11/18/11, indicated Emergency Medical Services were notified at 4:26 p.m., arrived at the facility at 4:34 p.m., and left the facility with the resident at 4:46 p.m. The dispatch complaint indicated "Hemorrhage/Laceration." On 11/18/11 at 6:00 p.m., nursing notes indicated a second nurse called her and said Resident #D attempted to cut her neck. The note indicated "Resident was at nurses station. There was a superficial cut from ear to ear. The CNA that was watching her at the nurses station told me that (Resident #D) had broken a bowl et (and) the CNA said she thought she had cleaned (up symbol) all the pieces, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Resident #D) must have had a piece hidden. The aid [sic] stated that she was walking et (and) saw (Resident #D) c (with) something in her hand going back and forth on her neck. The aid [sic] said she had just checked her..." On 1/31/12, at 2:30 p.m., the Administrator indicated the incident had not been reported to the ISDH. On 2/1/12 at 3:00 p.m., LPN #13, the nurse on duty on 11/18/11 when Resident #D cut her neck, was interviewed. She indicated she placed a clean dressing on the resident's neck and remained with the resident until the EMS arrived. The nurse indicated the wound appeared superficial but when the resident tipped her head backward the edges of the wound gapped open. The nurse indicated the wound was not bleeding. 3.1-13(g)(1)			